1-18-07

Honorable Judge Robert Drain
and Delphi Corp General Counsel
and Skadden, Arps, Slate, Meagher & Flom LLP

I Brenda Lawrence am writing in response of claim # 16271.

Response directed to Delphi
Claimant - Brenda Lawrence
Claim - Injured on the job 12-08-94
Chemical burn to right eye.

I have enclosed some random selections of documentation to evidence occurrence of injury and payments from GM or Delphi Work Comp. towards lost work time (approx. 6mo.) plus medical visits, medications and medical procedures afforded for me over the years.

I Thank-you for your concerns toward the continuant honoring of claims in regard to the periodic checkups and medical maintenance of my injured eye.

Respectfully,

Brenda Lawrence

Brenda Lawrence
P.O. Box 685
Davison, MI 48423

31005 000

EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

AN EMPLOYER SHALL REPORT IMMEDIATELY TO THE BUREAU ON FORM MDL-1-100 ALL INJURIES, INCLUDING DISEASES, WHICH ARISE OUT OF AND IN THE COURSE OF THE EMPLOYMENT, OR ON WHICH A CLAIM IS MADE AND RESULT IN ANY OF THE FOLLOWING: (A) DISABILITY EXTENDING BEYOND SEVEN (7) CONSECUTIVE DAYS, NOT INCLUDING THE DATE OF INJURY, (B) DEATH, (C) SPECIFIC LOSSES. IN CASE OF DEATH, AN EMPLOYER SHALL ALSO IMMEDIATELY FILE AN ADDITIONAL REPORT ON MDL-1-108.

I. EMPLOYEE DATA

1. SOCIAL SECURITY NUMBER	2. DATE OF INJURY	3. EMPLOYEE NAME (LAST, FIRST, MI)		
-7922	12/08/94	LAWRENCE, BRENDA A		
4. ADDRESS (NUMBER AND STREET)		5. CITY	6. STATE	7. ZIP CODE
		DAVISON	MI	48423
8. DATE OF BIRTH (MM/DD/YY)	9. SEX	10. NUMBER OF DEPENDENTS	11. TELEPHONE NUMBER	12. WORK PERMIT DATE IF UNDER AGE 1
	☐ MALE ☒ FEMALE	00		

13. TAX FILING STATUS
☒ A. SINGLE ☐ C. MARRIED, FILING JOINT
☐ B. SINGLE, HEAD OF HOUSEHOLD ☐ D. MARRIED, FILING SEPARATE

II. CURRENT EMPLOYER DATA

14. EMPLOYER NAME			15. FEDERAL I.D. NUMBER
GMC - AC ROCH - FLINT EAST			380572515 002
16. INJURY LOCATION CODE	17. MAILING LOCATION CODE	18. MESC NUMBER	19. TYPE OF BUSINESS (SIC)
002	122		AUTOMOTIVE
20. ADDRESS (NUMBER AND STREET)	21. CITY	22. STATE	23. ZIP CODE
PO BOX 1960	FLINT	MI	48501

III. SECOND EMPLOYER DATA

24. SECOND EMPLOYER NAME	25. SECOND EMPLOYER AWW	26. NUMBER WEEKS USED
	$	
27. ADDRESS (NUMBER AND STREET)	28. CITY	29. STATE	30. ZIP CODE

IV. ALLEGED INJURY DATA

31. LAST DAY WORKED	32. DATE EMPLOYEE RETURNED TO WORK (IF APPLICABLE)	33. DID EMPLOYEE DIE?
12/08/94		☐ YES ☒ NO

34. INJURY CITY	35. INJURY STATE	36. INJURY COUNTY	37. DID INJURY OCCUR ON EMPLOYER'S PREMISES?
FLINT	MI	25	☒ YES ☐ NO (IF NO, SEE ITEM 50)

38. DESCRIBE THE NATURE OF INJURY OR ILLNESS (EXAMPLE AMPUTATION, BURN, CUT, FRACTURE)
CHEMICAL BURNS

39. PART OF BODY DIRECTLY AFFECTED BY THE INJURY OR ILLNESS (EXAMPLE HAND, ARM, CIRCULATORY SYSTEM)
FACE, EYES

40. DESCRIBE THE EVENTS WHICH CAUSED THE INJURY (EXAMPLE FELL, OPERATING MACHINERY, CHEMICAL EXPOSURE)
CHEMICAL SPILL

41. NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE (EXAMPLE KNIFE, ACID, FLOOR, OIL)
CHEMICAL

V. OCCUPATION AND WAGE DATA

42. DATE HIRED	43. TOTAL GROSS WEEKLY WAGE (HIGHEST 39 OF 52)	44. NUMBER WEEKS USED	45. VALUE OF DISCONTINUED FRINGES
04/10/78	$ 27134.64	39	$

46. OCCUPATION (BE SPECIFIC)	47. WAS EMPLOYEE A VOLUNTEER WORKER?	48. WAS EMPLOYEE CERTIFIED AS VOCATIONALLY HANDICAPPED?
CONTAINER REPAIR MISC	☐ YES ☒ NO	☐ YES ☒ NO

49. DATE EMPLOYER NOTIFIED BY EMPLOYEE	50. IF TEMPORARY SERVICE AGENCY, PROVIDE NAME/ADDRESS OF EMPLOYER WHERE INJURY OCCURRED
12/08/94	

VI. PREPARER DATA I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

51. PREPARER'S SIGNATURE	52. TELEPHONE NUMBER	53. DATE PREPARED
WORK COMP ADMINISTRATOR	(810) 236-8700	01/18/95

NOTICE TO EMPLOYEE: QUESTIONS OR ERRORS SHOULD BE REPORTED IMMEDIATELY TO THE INDIVIDUAL LISTED ABOVE IN LINE 5

AUTHORITY: WORKERS' DISABILITY COMPENSATION ACT, R408.31(1)(3) COMPLETION: MANDATORY PENALTY: WORKERS' DISABILITY COMPENSATION ACT, 418.631	THE DEPARTMENT OF LABOR WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE NATIONAL ORIGIN, COLOR, MARITAL STATUS, HANDICAP, OR POLITICAL BELIEFS

LABOR

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Labor
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

FILING # 1

PART A

1. SECURITY NUMBER	2. DATE OF INJURY	3. EMPLOYEE NAME (LAST, FIRST, MI)	4 DEATH
-7922	12-08-94	LAWRENCE, Brenda A.	

6. E	7. CITY	8. STATE	9. ZIP CODE
	Davison	MI	48423

10. EMPLOYER NAME	11. FEDERAL I.D. NUMBER	12. INJURY LOCATION COD
A C Rochester East	380572515	002

13. EMPLOYER ADDRESS (NUMBER AND STREET)	14. CITY	15. STATE	16. ZIP CODE
1300 North Dort Highway	Flint	MI	48556

17. CARRIER OR SELF-INSURED NAME	18. NAIC OR SELF-INSURED NUMBER
General Motors Corporation	37999000A23
19. SERVICE AGENT NAME (IF APPLICABLE)	20. SERVICE AGENT I.D. NUMBER

21. ZIP CODE OF ISSUING OFFICE	22. CARRIER OR SELF-INSURED CLAIM NUMBER	23. DATE CARRIER RECEIVED NOTICE OF INJURY	24. DATE FIRST PAYMENT MADE
48501-1960		12-08-94	12-23-94

PART B

25. NATURE OF INJURY	26. PART OF BODY		
Chemical Burns	Face, Eyes		
27. AVERAGE WEEKLY WAGE	28. DISCONTINUED FRINGES	29. SECOND EMPLOYER A.W.W.	30. SECOND EMPLOYER DISCONTINUED FRINGES
$ 695.76	$ -0-	$	$
31. TAX FILING STATUS ON DATE OF INJURY A	32. LAST DAY WORKED	33. NUMBER OF DAYS IN WORK WEEK	34. NUMBER OF DEPENDENTS
	12-08-94	5	00

PART C

35. REASON FOR FILING	36 WEEKLY COMPENSATION BASE RATE
A	$ 404.43

37. WEEKLY ADJUSTMENTS TO BASE RATE ____ $ ____ ____ $ ____ ____ $ ____ ____ $ ____
____ $ ____ ____ $ ____ ____ $ ____ ____ $ ____

38. WEEKLY AMOUNT BEING REIMBURSED BY A FUND (NOT REPORTED IN LINE 37) ____ $ ____ ____ $ ____ ____ $ ____ ____ $ ____

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	TERMINATION REASON
A	A		404.43	12-09-94	12-31-94	1,294.18	
A	A		404.43	01-01-95			

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K", ENTER ORDER # _____

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS ____/____/____

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER", PLEASE BE SPECIFIC _____

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE.

39. AUTHORIZED SIGNATURE	40 PERSON HANDLING CLAIM (PLEASE PRINT)	41. TELEPHONE NUMBER	42. DATE
Bettye Jefferson	Bettye Jefferson	810-236-8692	03-22-95

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

MDL-1-701 (REV. 5-91) FRONT FORMERLY FORM 101 AND 102

WORKERS' COMPENSATION HEALTH CARE SERVICES
NOTIFICATION OF BILL ADJUSTMENT

COPY 1 PROVIDER
COPY 2 CARRIER
COPY 3 EMPLOYEE

Michigan Department of Labor/Bureau of Workers' Disability Compensation
Health Care Services Division
P.O. Box 30016
Lansing, Michigan 48909

DATE PROCESSED: 04/25/96
PAGE: 1

CARRIER NAME	ICN	TELEPHONE NUMBER
GENERAL MOTORS\FLINT-MED	08952713200004	(800)937-6824

STREET ADDRESS	CITY	STATE	ZIP CODE	CLAIM NUMBER
38705 SEVEN MILE RD	LIVONIA	MI	48152	79221208

EMPLOYER NAME	OTHER REFERENCE NO#	NAIC/SELF-INSURED NUMBER
31005-000	2535	37999000A23

THIS FORM IS REQUIRED AS SET FORTH IN PART 19, R 418.1901(1) AND R 418.1904(1) OF THE WORKER'S COMPENSATION HEALTH CARE SERVICES RULES.

PROVIDER NAME	EMPLOYEE NAME
HURLEY MED CTR SURGERY	BRENDA A LAWRENCE
STREET ADDRESS: PO BOX 1710	STREET ADDRESS: PO BOX 113
CITY: FLINT, STATE: MI, ZIP CODE: 485011710	CITY: SWARTZ CREEK, STATE: MI, ZIP CODE: 484730113
SOCIAL SECURITY/FEIN NUMBER*: 386005601	SOCIAL SECURITY NUMBER*: -7922
PATIENT ACCOUNT NUMBER: 677H1770971	DATE OF BILL*: 04/25/96
	DATE OF INJURY: 12/08/94

DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE	DESCRIPTION--IF NEEDED	DIAGNOSIS CODE	UNITS	CHARGES	PAYMENT	NOTE**
12/08/94	2	99244	OFC CONSULT-NEW/EST PAT	94102	00001	110.00	110.00	

EMPLOYEE: **FOR INFORMATION ONLY. THIS IS NOT A BILL.** IF YOU ARE BILLED FOR ANY SERVICES RELATED TO THIS WORKERS' COMPENSATION CLAIM, DO NOT PAY; DO CALL THE CARRIER LISTED ABOVE.

THIS IS NOT A BILL

TOTAL CHARGE	PAYMENT
110.00	110.00

PROVIDER: IF YOU INTEND TO SEEK RECONSIDERATION, PLEASE ADVISE THE CARRIER INDICATED ABOVE WITHIN 30 CALENDAR DAYS OF RECEIPT OF THIS NOTICE AND FORWARD THE INFORMATION INDICATED IN THE NOTE COLUMN.

PROVIDER/EMPLOYEE: R 418.114 AND RULE 1901(2) OF THE WORKERS' COMPENSATION HEALTH CARE SERVICES RULES REQUIRE THAT THE CARRIER NOTIFY THE EMPLOYEE AND THE PROVIDER THAT THE RULES PROHIBIT A PROVIDER FROM BILLING AN EMPLOYEE FOR ANY AMOUNT FOR HEALTH CARE SERVICES PROVIDED FOR THE TREATMENT OF A COVERED WORK-RELATED INJURY OR ILLNESS WHEN THAT AMOUNT IS DISPUTED BY THE CARRIER PURSUANT TO ITS UTILIZATION REVIEW PROGRAM, OR WHEN THE AMOUNT EXCEEDS THE MAXIMUM ALLOWABLE PAYMENT ESTABLISHED BY THESE RULES. THE CARRIER SHALL REQUEST THE EMPLOYEE TO NOTIFY THE CARRIER IF THE PROVIDER BILLS THE EMPLOYEE.

THE DEPARTMENT OF LABOR WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, HANDICAP OR POLITICAL BELIEFS.

* PROTECTED INFORMATION TO BE USED FOR INDENTIFCATION PURPOSES